STATE OF GEORGIA
DEPARTMENT OF MOTOR VEHICLE SAFETY

LICENSE NO. _____ DATE _____

APPLICANT'S FULL NAME _____

STREET ADDRESS _____

CITY _____ STATE_____ DOB_____

REPORT ON VISUAL EXAMINATION

DISTANT VISION ONLY	RIGHT EYE	LEFT EYE	BOTH EYES
WITHOUT GLASSES	20/_____	20/_____	20/_____
WITH PRESENT GLASSES	20/_____	20/_____	20/_____
WITH NEW PRESCRIPTION	20/_____	20/_____	20/_____
WITH BIOPTIC PRESCRIPTION	20/_____	20/_____	20/_____

IF POSSIBLE MEASURE ABOVE AT 20 FEET IF NOT PLEASE STATE DIST. USED

FIELDS-HORIZONTAL PERCEPTION	RIGHT	LEFT	TOTAL

EVIDENCE OF SUPPRESSION_____

COORDINATION AT 20 FEET EXO_____ ESO_____RT. H_____ LF. H_____

FUSION-DISTANCE	EXCELLENT	GOOD	POOR	NONE	TEST USED
FUSION-NEAR	EXCELLENT	GOOD	POOR	NONE	TEST USED
DEPTH PERCEPTION	EXCELLENT	GOOD	POOR	NONE	TEST USED
COLOR VISION	NORMAL	DEFICIENT		FAIL	TEST USED

CHECK HERE IF CORRECTION IS ACHIEVED WITH OTHER THAN CONVENTIONAL LENSES (BIOPTICS). IF SO A DETAILED REPORT MUST BE ATTACHED.

APPLICANT SHOULD RETURN TO DRIVER LICENSE CENTER
OR
PHYSICIAN MUST MAIL COMPLETED FORM TO:

DEPARTMENT OF MOTOR VEHICLE SAFETY
ATTN: MEDICAL ADVISORY BOARD
P.O. BOX 80447
CONYERS, GEORGIA 30012
(678) 413-8417

TO EXAMINING DOCTOR:

Kindly complete this form on both sides. Please leave blank any spaces for test on which you have made no examination. If the case is peculiar, any additional comments on a separate sheet would be appreciated.

IMPORTANT: For proper identification, will you please have the person whom you have examined sign the report in your presence.

SIGN HERE: _____

Are corrective lenses needed for distant vision? ____ For near vision_____? Is there any double vision? _____ If so, is it corrected with glasses or other treatment?_____ Any evidence of eye disease or injury? _____ If so describe: _____

_____

Can this be corrected or compensated for? _____

Any difficulty in seeing in dim light or at night? _____

In your opinion, does this person have sufficient vision to operate a motor vehicle safety? ____ If yes, should there be any restrictions imposed? _____ If so what restrictions?

_____

COMMENTS:_____

_____

CERTIFICATION OF VISION SPECIALIST

I, _____
being licensed to practice in Georgia, certify that I have personally examined the vision of the above named, that a true record of this examination appears on this report and that he or she signed this forming my presence.

Signature of examining Doctor:_____

Business Address:_____

Business Phone Number:_____

Today's Date:_____

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